CAUTION: Read the ICD-9 Policy Holding Library page about policy in this document.

Pharmacy Claim Form (30-1) Examples 1

The examples in this section are to assist providers in billing on the *Pharmacy Claim Form* (30-1). Refer to the *Pharmacy Claim Form (30-1) Completion* section of this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Billing Tips: Quantities must be in the metric decimal if the quantity is not a whole number. Do not round the quantity. For example, a quantity of 3.5 Gm should be expressed as 3.500, rather than rounding to 4. Do not include measurement units such as Gm or cc. All information on an attachment must match the information entered on the claim form. For information on rounding, see the *Pharmacy Claim Form (30-1) Completion* section in this manual.

Compounded Prescription

Refer to the *Compound Drug Pharmacy Claim Form* (30-4) *Examples* section for compound billing examples.

Late Billing

Figure 1. Late billing.

This is a sample only. Please adapt to your billing situation.

In this example a pharmacist is submitting a claim after the six-month billing limit. The claim is submitted late because the proof of eligibility was unknown on the date of service.

The date of service is the date that the prescription was filled; however, do not bill Medi-Cal until the patient or representative of the patient has received the prescription. The date is entered in an eight-digit MMDDYYYY (Month, Day, Year) format in the *Date of Service* field (Box 12). In this example, September 15, 2007 is entered as "09152007."

In this example, the *Days Supply* field (Box 15) indicates the drug is expected to last 10 days.

Because this claim was submitted late (the proof of eligibility was unknown on the date of service), a "1" is entered in the *Billing Limit Exceptions* field (Box 88). The date that proof of eligibility was received is entered in the *Specific Details/Remarks* area. In this example, proof of eligibility was received on September 24, 2007, entered as: "PROOF OF ELIGIBILITY RECEIVED 09242007." See the *Pharmacy Claim Form (30-1) Submission and Timeliness Instructions* section of this manual for more information about billing limit exception codes.

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[redacted]

1 CLAIM CONTROL NUMBER * FOR F.I. USE ONLY

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PHARMACY CLAIM FORM

Provider Name, Address

ABC PHARMACY
1234 MAIN STREET
ANYTOWN CA

Provider Phone Number: **916-555-5555**

2 ID QUALIFIER	3 PROVIDER ID
05	0123456789

4 ZIP CODE
999995555

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

ELITE PICA ← TYPEWRITER ALIGNMENT → ELITE PICA

PATIENT INFORMATION

5 PATIENT NAME (LAST, FIRST, MI)	6 MEDI-CAL IDENTIFICATION NO	CD EXCEPT	7 SEX	8 DATE OF BIRTH	9 PATIENT LOCATION	10 MEDICARE STATUS
DOE JANE	90000000A95001		F	03051960 MM DD YYYY		

1

11 PRESCRIPTION NO	12 DATE OF SERVICE	13 METRIC QUANTITY	14 CODE 1 MET?	15 DAYS SUPPLY	16 BASIS OF COST DETERMINATION
1234567	09152007 MM DD YYYY	180 . 000 WHOLE UNITS . DECIMAL	Y	10	00

17 PROD ID QUAL	18 PRODUCT ID	19 ID QUAL	20 PRESCRIBER ID	21 PRIMARY ICD-CM	22 SECONDARY ICD-CM
03	00001123401	08	1234567890		

23 CHARGE	24 OTHER COVERAGE PAID	25 OTH COV CODE	26 PATIENT'S SHARE	27 TAR CONTROL NO	28 COMP CODE	29 DELETE
1700		0				Y

2

30 PRESCRIPTION NO	31 DATE OF SERVICE	32 METRIC QUANTITY	33 CODE 1 MET?	34 DAYS SUPPLY	35 BASIS OF COST DETERMINATION
	MM DD YYYY	WHOLE UNITS . DECIMAL	Y		

36 PROD ID QUAL	37 PRODUCT ID	38 ID QUAL	39 PRESCRIBER ID	40 PRIMARY ICD-CM	41 SECONDARY ICD-CM

42 CHARGE	43 OTHER COVERAGE PAID	44 OTH COV CODE	45 PATIENT'S SHARE	46 TAR CONTROL NO	47 COMP CODE	48 DELETE
						Y

3

49 PRESCRIPTION NO	50 DATE OF SERVICE	51 METRIC QUANTITY	52 CODE 1 MET?	53 DAYS SUPPLY	54 BASIS OF COST DETERMINATION
	MM DD YYYY	WHOLE UNITS . DECIMAL	Y		

55 PROD ID QUAL	56 PRODUCT ID	57 ID QUAL	58 PRESCRIBER ID	59 PRIMARY ICD-CM	60 SECONDARY ICD-CM

61 CHARGE	62 OTHER COVERAGE PAID	63 OTH COV CODE	64 PATIENT'S SHARE	65 TAR CONTROL NO	66 COMP CODE	67 DELETE
						Y

4

68 PRESCRIPTION NO	69 DATE OF SERVICE	70 METRIC QUANTITY	71 CODE 1 MET?	72 DAYS SUPPLY	73 BASIS OF COST DETERMINATION
	MM DD YYYY	WHOLE UNITS . DECIMAL	Y		

74 PROD ID QUAL	75 PRODUCT ID	76 ID QUAL	77 PRESCRIBER ID	78 PRIMARY ICD-CM	79 SECONDARY ICD-CM

80 CHARGE	81 OTHER COVERAGE PAID	82 OTH COV CODE	83 PATIENT'S SHARE	84 TAR CONTROL NO	85 COMP CODE	86 DELETE
						Y

SPECIFIC DETAILS/REMARKS:

PROOF OF ELIGIBILITY RECEIVED 09242007

This is to certify that the information contained above is true, accurate, and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on the back of this form.

X *Robert Smith, Pharm D.*
94 Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form

87 MEDICAL RECORD NO	88 BILL LIM EX	89 ATTACHMENTS
	1	

90 DATE BILLED	91 DISCHARGE DATE	F.I. USE ONLY	
12 01 2007 MM DD YYYY	MM DD YYYY	92	93

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Figure 1. Late Billing.

Code I Restricted Drug

Figure 2. Code I restricted drug.

This is a sample only. Please adapt to your billing situation. Sample attachments are not illustrated in this example.

In this example a pharmacist is submitting a claim for a drug with a Code I restriction.

The 14-character recipient ID number as it appears on the Benefits Identification Card (BIC) is entered in the *Medi-Cal Identification Number* field (Box 6).

A "Y" is entered in the *Code I Restrictions Met?* field (Box 14) to indicate that all Code I requirements have been met. See the *California Code of Regulations* (CCR), Title 22, Section 51476(c) for more information about documenting Code I requirements.

The biller uses fields 30-86 only for additional items to be billed for the same recipient during the same month of service.

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1 CLAIM CONTROL NUMBER * FOR F.I. USE ONLY

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PHARMACY CLAIM FORM

Provider Name, Address

ABC PHARMACY
1234 MAIN STREET
ANYTOWN CA

Provider Phone Number: **916-555-5555**

2 ID QUALIFIER	3 PROVIDER ID
05	0123456789

4 ZIP CODE: 999995555

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

ELITE PICA ← TYPEWRITER ALIGNMENT → ELITE PICA

PATIENT INFORMATION
5 PATIENT NAME (LAST, FIRST, MI): DOE JOHN
6 MEDI-CAL IDENTIFICATION NO: 90000000A95001 CD EXCEPT
7 SEX: M
8 DATE OF BIRTH: 03051960 MM DD YYYY
9 PATIENT LOCATION:
10 MEDICARE STATUS:

1

11 PRESCRIPTION NO	12 DATE OF SERVICE	13 METRIC QUANTITY	14 CODE 1 MET?	15 DAYS SUPPLY	16 BASIS OF COST DETERMINATION
1234567	09152007 MM DD YYYY	6 . 000 WHOLE UNITS . DECIMAL	Y	6	00

17 PROD ID QUAL	18 PRODUCT ID	19 ID QUAL	20 PRESCRIBER ID	21 PRIMARY ICD-CM	22 SECONDARY ICD-CM
03	00001123401	08	1234567890		

23 CHARGE	24 OTHER COVERAGE PAID	25 OTH COV CODE	26 PATIENT'S SHARE	27 TAR CONTROL NO	28 COMP CODE	29 DELETE
972		0				Y

2

30 PRESCRIPTION NO	31 DATE OF SERVICE	32 METRIC QUANTITY	33 CODE 1 MET?	34 DAYS SUPPLY	35 BASIS OF COST DETERMINATION
	MM DD YYYY	WHOLE UNITS . DECIMAL	Y		

36 PROD ID QUAL	37 PRODUCT ID	38 ID QUAL	39 PRESCRIBER ID	40 PRIMARY ICD-CM	41 SECONDARY ICD-CM

42 CHARGE	43 OTHER COVERAGE PAID	44 OTH COV CODE	45 PATIENT'S SHARE	46 TAR CONTROL NO	47 COMP CODE	48 DELETE
						Y

3

49 PRESCRIPTION NO	50 DATE OF SERVICE	51 METRIC QUANTITY	52 CODE 1 MET?	53 DAYS SUPPLY	54 BASIS OF COST DETERMINATION
	MM DD YYYY	WHOLE UNITS . DECIMAL	Y		

55 PROD ID QUAL	56 PRODUCT ID	57 ID QUAL	58 PRESCRIBER ID	59 PRIMARY ICD-CM	60 SECONDARY ICD-CM

61 CHARGE	62 OTHER COVERAGE PAID	63 OTH COV CODE	64 PATIENT'S SHARE	65 TAR CONTROL NO	66 COMP CODE	67 DELETE
						Y

4

68 PRESCRIPTION NO	69 DATE OF SERVICE	70 METRIC QUANTITY	71 CODE 1 MET?	72 DAYS SUPPLY	73 BASIS OF COST DETERMINATION
	MM DD YYYY	WHOLE UNITS . DECIMAL	Y		

74 PROD ID QUAL	75 PRODUCT ID	76 ID QUAL	77 PRESCRIBER ID	78 PRIMARY ICD-CM	79 SECONDARY ICD-CM

80 CHARGE	81 OTHER COVERAGE PAID	82 OTH COV CODE	83 PATIENT'S SHARE	84 TAR CONTROL NO	85 COMP CODE	86 DELETE
						Y

SPECIFIC DETAILS/REMARKS:

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X *Robert Smith, Pharm D.*
94 Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form

87 MEDICAL RECORD NO:
88 BILL LIM EX:
89 ATTACHMENTS:
90 DATE BILLED: 12 01 2007 MM DD YYYY
91 DISCHARGE DATE:
F.I. USE ONLY 92 93

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Figure 2. Code I Restricted Drug.

Other Health Coverage

Figure 3. Other Health Coverage (OHC).

This is a sample only. Please adapt to your billing situation. Sample attachments are not illustrated in this example.

In this example, the recipient has OHC. The pharmacy billed the primary insurance and received payment.

The pharmacy bills the other health company and gets a request for a $10.00 co-payment. The co-payment can be misleading because Medi-Cal pays the difference between the Medi-Cal allowed amount less the payment from the other coverage. The other health company paid $66.96 and this amount is entered in the *Other Coverage Paid* field (Box 24).

Because OHC exists and payment has been collected, a “9” is entered in the *Other Cov Code* field (Box 25). The provider is certifying that the other health insurance was billed and must have documentation readily retrievable to verify this transaction.

Charge filed is the pharmacy’s charge to the general public.

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1 CLAIM CONTROL NUMBER * FOR F.I. USE ONLY

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8

PHARMACY CLAIM FORM

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1234 MAIN STREET
ANYTOWN CA

Provider Phone Number: **916-555-5555**

2 ID QUALIFIER	3 PROVIDER ID
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999995555

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

ELITE PICA ← TYPEWRITER ALIGNMENT → ELITE PICA

PATIENT INFORMATION

5 PATIENT NAME (LAST, FIRST, MI)	6 MEDI-CAL IDENTIFICATION NO	CD	7 SEX	8 DATE OF BIRTH	9 PATIENT LOCATION	10 MEDICARE STATUS
DOE JANE	90000000A95001		F	03051960 MM DD YYYY		

1

11 PRESCRIPTION NO	12 DATE OF SERVICE	13 METRIC QUANTITY		14 CODE 1 MET?	15 DAYS SUPPLY	16 BASIS OF COST DETERMINATION
1234567	09152007 MM DD YYYY	100 WHOLE UNITS	000 DECIMAL	Y	100	

17 PROD ID QUAL	18 PRODUCT ID	19 ID QUAL	20 PRESCRIBER ID	21 PRIMARY ICD-CM	22 SECONDARY ICD-CM
03	00001123401	08	1234567890		

23 CHARGE	24 OTHER COVERAGE PAID	25 OTH COV CODE	26 PATIENT'S SHARE	27 TAR CONTROL NO	28 COMP CODE	29 DELETE
7500	6696	9				Y

2

30 PRESCRIPTION NO	31 DATE OF SERVICE	32 METRIC QUANTITY		33 CODE 1 MET?	34 DAYS SUPPLY	35 BASIS OF COST DETERMINATION
	MM DD YYYY	WHOLE UNITS	DECIMAL	Y		

36 PROD ID QUAL	37 PRODUCT ID	38 ID QUAL	39 PRESCRIBER ID	40 PRIMARY ICD-CM	41 SECONDARY ICD-CM

42 CHARGE	43 OTHER COVERAGE PAID	44 OTH COV CODE	45 PATIENT'S SHARE	46 TAR CONTROL NO	47 COMP CODE	48 DELETE
						Y

3

49 PRESCRIPTION NO	50 DATE OF SERVICE	51 METRIC QUANTITY		52 CODE 1 MET?	53 DAYS SUPPLY	54 BASIS OF COST DETERMINATION
	MM DD YYYY	WHOLE UNITS	DECIMAL	Y		

55 PROD ID QUAL	56 PRODUCT ID	57 ID QUAL	58 PRESCRIBER ID	59 PRIMARY ICD-CM	60 SECONDARY ICD-CM

61 CHARGE	62 OTHER COVERAGE PAID	63 OTH COV CODE	64 PATIENT'S SHARE	65 TAR CONTROL NO	66 COMP CODE	67 DELETE
						Y

4

68 PRESCRIPTION NO	69 DATE OF SERVICE	70 METRIC QUANTITY		71 CODE 1 MET?	72 DAYS SUPPLY	73 BASIS OF COST DETERMINATION
	MM DD YYYY	WHOLE UNITS	DECIMAL	Y		

74 PROD ID QUAL	75 PRODUCT ID	76 ID QUAL	77 PRESCRIBER ID	78 PRIMARY ICD-CM	79 SECONDARY ICD-CM

80 CHARGE	81 OTHER COVERAGE PAID	82 OTH COV CODE	83 PATIENT'S SHARE	84 TAR CONTROL NO	85 COMP CODE	86 DELETE
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87 MEDICAL RECORD NO	88 BILL LIM EX	89 ATTACHMENTS

90 DATE BILLED	91 DISCHARGE DATE	F.I. USE ONLY	
12 01 2007	MM DD YYYY	92	93

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM. FORWARD TO APPROPRIATE F.I.

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Figure 3. Other Health Coverage